Please return completed registration card to the front desk.

Patient's First Name:

Patient's Last Name:

Email:

Date of Birth: / /

Telephone: ( )

[ ] Requesting proxy access for minor age 12 and younger
[ ] Requesting proxy access for patient age 13 and over due to patient's impaired decision making capacity.

Doctor signature required and HIPAA form or other DPOA filled out if doctor requires
Form scanned into chart

Relationship to Patient:

Proxy Grantee's First Name:

Proxy Grantee's Last Name:

Proxy Grantee's Email:

Proxy Grantee's Address:

Proxy Grantee's City, State, Zip

Proxy Grantee's Telephone: ( )

Proxy Grantee's Cell-phone: ( )

Physician Signature:

Patient Signature:

St.JosephHealth℠

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